DEDUCTIBLE REIMBURSEMENT REQUEST FORM

For Employees of Christian Family Care

Send the following items to the email, fax, or address below:

1. Completed Deductible Reimbursement Request Form
2. Explanation of Benefits (EOB) from **BCBS of Arizona**

Email: submit@fbcserv.com
Fax : 602.277.8067
Mail: FBC
7639 E Pinnacle Peak Road, Suite 100
Scottsdale, AZ 85255

SCAN ME

Online: Download app by visiting myfbcapp.com
OR Scan the QR code with your phone camera

APP CODE: OEOHEY

Deductible Reimbursement: After the first $1,600 of the deductible, Christian Family Care will reimburse employees and their dependents 80% of the last $4,400 of the deductible ($3,520) for in-network services only.

To receive reimbursement, send an Explanation of Benefits (EOB) and Request Form to FBC when you are required to pay a deductible.

Please help FBC process your request for reimbursement
by providing the following information:
(please print)

Submittal Date: _____ Total Pages: _____

Employee Name: _____ Daytime Phone: _____

Employee Email: _____

Request for reimbursement is made for out-of-pocket medical expenses for:

☐ Myself

☐ My Dependent (First & Last Name): _____

AUTHORIZATION & CERTIFICATION:
I authorize FBC to review the documentation I have provided in this transmission. I understand that this information will be used only for the purposes for which it is intended and will not be disclosed to other parties without my express permission.
I certify that I am claiming reimbursement for only eligible expenses incurred during the 2024 plan year and only for eligible plan participants.

_____ Signed

_____ Date